SF SF 2050P# (7-96)
Supersedes (7-95) issue

Date/Time Run 10/26/95 11:03:26

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Sandia National Laboratories

REPORT OF OCCUPATIONAL INJURY/ILLNESS

(Based on the OSHA definitions and reqirements which may or may not be consistent with various state compensation laws)

NOTICE OF ACCIDENT

(Pursant to Chapter 52, NMSA 1978 section 52-1-29)

FOR MEDICAL USE ONLY

Date received in Medical _____ Case No. _____ Date received in Safety _____

Name(Last, First, MI)	Org.	Mail Stop	Sex	Date of Birth	Age	Social Security Number

Date of Incident	Incident Day of Week	Time of Day	Location of Incident (Bldg/Room)	Incident was:	Service Date

Job Category (Secretary, electrician, painter, scientist, mechanical tech, etc)	Job experience [(yr(s)mo(s)]	Witness(es)

Briefly describe the activity you were performing and how the incident occured _____

Employee Signature _____ Work Phone _____ Date _____

CONTRACTOR INFORMATION - PLEASE COMPLETE THE FOLLOWING INFORMATION

Company Name (Contract Use Only)	Phone	Name of SNL Supervisor /Inspector	Org.	M.S.	Phone

Workdays Lost	Workdays Restricted	Type of Injury

INVESTIGATION - MANAGER (Foreman, Inspector, etc.)

A. Was place of Incident or exposure on Sandia's premises Yes ☐ No ☐

B. Was employee sent home due to incident? Yes ☐ No ☐

C. What was the employee doing when incident occured? Be Specific
(Was employee using tools, equipment, handling material?, Name them., What was employee doing with them?)

_____

D. How did the incident occur? What was the cause? Describe the event in full detail.
Name any objects or substances involved and tell how they were involved.

_____

E. What has been done to correct conditions causing the incident?

_____

F. What remains to be done to correct such conditions? By what date?

Manager's Name (print or type) _____

Manager's Signature _____ Org _____ M.S. _____

Date _____ Phone _____

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MEDICAL INFORMATION

Diagnosis

_____

- ☐ Deferred
- ☐ Fracture
- ☐ Loss of Consciousness
- ☐ FB Removal (Medical)
- ☐ FB Removal (First Aid)

Treatment

- ☐ First Aid Only
- ☐ Debridement
- ☐ Sutures
- ☐ Prescription Medication
- ☐ OTC Medication
- ☐ Steri-strip/Butterfly
- ☐ Splint (Support)
- ☐ Splint (Immobilize)

Disposition

- ☐ Outside Referral
- ☐ Physical Therapy
- ☐ Sent Home
- ☐ Accommodations
- ☐ None of the Above

Examined by physician/NP/PA? Yes ☐ No ☐ Attending medical professional name: _____

SAFETY INFORMATION

DOE Case Recordable Yes ☐ No ☐ Were corrective actions discussed with Manager Yes ☐ No ☐

Investigative Comments/Corrective Action See Attachement ☐ Not Work Related ☐

Safety and Health Representative	Org	M.S.	Phone	Date

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